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Today's Community Concept of School Health

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Great strides have been made in school health in the relatively short period since 1894, when the first school health program in the United States was established in Boston. In those days public schools were "hotbeds of contagion," and it was not uncommon for school doctors to find children with diphtheria, whooping cough or scarlet fever in the classroom. The position that health occupies in the schools today is the result of an evolutionary process which can be roughly divided into five stages:

Stage I was characterized by an effort to detect and exclude those pupils who, because of communicable disease, threatened the welfare of others.

In Stage II there was added the responsibility of finding pupils with physical defects, and of taking steps to secure corrections.

Stage III was marked by a growing consciousness that health activities were carried out not only for corrections but for educational values as well.

Stage IV was marked by an expansion of Stage III, and included such concepts as: (a) all teachers are health teachers, (b) personal health includes physical, mental and emotional health, (c) the health program concerns itself with community as well as personal health, (d) health education is a 24-hour-a-day program—365 days a year, and involves the cooperation of the home and community agencies as well as the schools.

Stage V, the present one, is marked by a growing realization on the part of schools, health departments, professional groups and community organizations of their interdependence in carrying out the school health program. They recognize that each has a contribution to make and that no one of them can do the job alone.

Each advanced stage has included the best of the practices and experiences gained from earlier stages.

School health programs have steadily increased in breadth of services and complexity of organization. Forty years ago all health responsibility in the school was assumed by the doctor or the nurse, but this is not the case today. Today the job is shared with teachers, parents, dentists and dental hygienists, psychologists, psychiatric social workers and psychiatrists, health educators, counselors, students and others. This has required the setting up of machinery within the school for coordinating efforts of various professional workers and groups involved in the school health program. This has usually taken the form of a school health committee, a health coordinator, or both.

The modern school health program, to be most effective, must also be in proper relationship to other community programs of public health and child welfare. The idea that the school health program should be an isolated endeavor, operating apart from the rest of the community is being strongly challenged. There is a growing acceptance of the fact that, in general, the school child's health reflects the foundation of his health laid during the preschool years, the health of his family and the adequacy of health facilities in the community in which he lives.

Parents have the primary responsibility for the health of their children. How well the family meets its responsibility in relation to providing food, rest, recreation, and medical and dental services, plus a healthful environment, is a highly important factor in relation to the child's health status. The job of the school health worker is to help motivate the parent to carry out

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responsibilities of the home and to stimulate citizens to provide necessary community facilities.

Today's community concept recognizes the advantages of integrating school health services with community health services, of promoting the health of parents, especially mothers during the prenatal period, and of providing continued health supervision during infancy, childhood and adulthood.

Not only do community health program activties affect the school child, but the family health status is frequently influenced through the school health program. For example, a nurse-parent conference or a medical examination at school may reveal a family health problem of greater significance and urgency than the child's health problem alone. Clearly, solution of a family health problem also benefits the child.

On every hand there is evidence of the ever-increasing interest and activity in school health work, not only by schools and health departments, but also by parent groups, medical and dental societies and other community agencies.

Two years ago the National Congress of Parents and Teachers asked the House of Delegates of the American Medical Association to request state medical societies to appoint committees or arrange for representation in conferences in the several states between medical societies, dental societies, health departments, educational agencies and the National Congress of Parents and Teachers, looking toward the improvement of health services and health education for school children. The American Medical Association demonstrated its interest by calling two conferences, one in 1947 and the second in 1949, to define the role of the practicing physician in the school health program. From these conferences came recommendations that every local medical society should appoint a school health committee to study ways in which the physician's time may be used more effectively in the schools. Several local medical societies in California have already appointed school health committees which are cooperating with the schools in the development of the school health program.

Another promising development in recent years has been the increase in cooperation between schools and health departments in relation to the school health program. Most states now have formal plans for cooperation between state health departments and state departments of education with respect to school health programs. In California the closely related work of the State Departments of Education and Public Health in their responsibilities for the health of the school-age child is coordinated through the California State Joint Committee on School Health.

On the local level, an increasing number of county and city joint school health councils are being formed in California. Some have been initiated by the schools, others by the local health department. While council representation varies, it usually includes school administrators and teachers, members of the school health staff, health department representatives, parents, representatives of medical and dental societies, voluntary health agencies and other community organizations with a particular interest in child health.

The school health council facilitates joint program planning and the formulation of policies to guide the school health program. Fullest use of community resources is possible only when there is joint planning and active participation of many different community groups.

Joint planning, with a sharing of responsibilities for different aspects of the program, has become a more and more common practice, particularly in rural areas where neither schools nor health departments have sufficient staff or resources to carry out an adequate program alone. A division of responsibilities and a sharing of personnel between schools and health departments makes possible the fullest utilization of existing facilities and permits the best use of professional skill and time. Almost universally, both schools and health departments are under-staffed and cannot afford to use the time of their personnel for any but the most essential and most productive activities. They cannot afford the luxury of duplicating services.

However, there are many communities in which this fine working relationship and this spirit of cooperation, which is so conducive to developing the best type of school health program, do not prevail. Although school health policies of a general nature have been formulated and approved by many national health and education organizations for at least 10 years, and are now well established, they affect school health practices in all *too* few local areas. Joint planning of school health programs would give an opportunity to review and discuss these policies in terms of how well they are fitted to local situations and to apply those which are workable.

Joint planning opens the way to a critical analysis of the total school health program with a view of determining what the needs are and then deciding how best they can be met regardless of what the traditional pattern has been. Some of the patterns in use today were established at the turn of the century and do not take into consideration the newer knowledge concerning the growth and development and the behavior of children, nor do they recognize improved school health

methods and practices, which have demonstrated their worth.

There have been many recent advances in school health, such as: (1) the increased participation of the classroom teacher, (2) improved school health records (which more fully utilize the contribution of the teacher, nurse and physician), (3) improved screening devices to select pupils with probable vision defects and hearing losses, (4) greater participation by practicing physicians, (5) fewer but more thorough medical examinations giving priority to referred cases and new entrants, (6) the establishment of otological, cardiac and other diagnostic facilities which provide a more accurate diagnosis of pupil health problems, and (7) establishment of more adequate special education facilities for children with handicapping defects.

Despite these examples of progress, many of the answers pertaining to the school health program are still unknown. There is a great need for experimentation. For example, there are great gaps in our knowledge concerning a proper secondary school health program. There is a need for trying new methods in an attempt to find out what works and what doesn't work under today's conditions. Continual program evaluation is needed in order for us to modify our activities and to make them more successful, retaining things that prove to be effective and dropping those which prove ineffective.

Stanislaus County Wants Nurses

Dr. George F. O'Brien, Stanislaus County Health Officer, announces vacancies for public health nurses to work in a generalized program. Salary range is $277 to $333, with retirement, 15 working days vacation, and sick leave accumulative to 50 days. A car is furnished. PHN certificate and California registration required. Address Doctor O'Brien, Box 1412, Modesto, for further details.

Hospital Nursing Guide

"A Guide to Nursing Care for Maternity Patients and Newborn Infants in Hospitals" has been developed by the Bureau of Maternal and Child Health. This guide, designed to help hospitals formulate written manuals on nursing procedures, has been prompted by numerous requests for such material. It is an outgrowth of consultation services to hospitals which have been carried on during the past six years by the Hospital Nursing Consultants on the staff of the State Department of Public Health. Copies are available from the Bureau of Health Education, Room 521, Phelan Building, 760 Market St., San Francisco 2.

Federal Surplus Property Available to Health Departments, Hospitals

A recently amended federal law, which since June, 1949, has made federal surplus properties available to educational institutions, now also permits the donation of such properties to health departments and to other tax-supported or nonprofit medical institutions, hospitals, or clinics. The only charge to the institution for the material, which includes equipment and supplies, is the cost of handling and shipping.

A large quantity of surplus property is available for inspection at three warehouses maintained by the State Surplus Property Agency as follows:

Oakland: 7425 San Leandro St.
Los Angeles: 6500 Avalon Blvd.
Sacramento: 1800 11th St.

Institutions or health departments interested in this material should plan to either visit the warehouse or contact the State Surplus Property Agency at any of the addresses listed. The agency is prepared to deliver surplus property to qualified hospitals and health departments immediately. To qualify for the donation of surplus personal property the institution must be tax-supported or must be a nonprofit corporation, as defined in Section 101 of the Internal Revenue Code.

Surplus property was first made available to educational institutions with the enactment of Public Law 152 on June 30, 1949. The State Department of Education has been distributing this material to educational institutions for some time. As amended by Public Law 754 on September 5, 1950, the provision now extends the availability of federal surplus personal property to tax-suported or nonprofit health and medical agencies. The law also permits sale of real property, including buildings, fixtures and equipment situated thereon.

McCarthy Joins C. T. H. A. Staff

Jay E. McCarthy, health education consultant with the State Department of Public Health for the past seven years, has accepted a position as Director of Health Education of the California Tuberculosis and Health Association. His new job, recently created by CTHA, will serve to coordinate health education activities of tuberculosis associations throughout the State.

Nursing Vacancies in Sacramento

The Sacramento City Health Department announces two nursing vacancies, with salary range from $266 to $319. A car is furnished. Inquiries should be directed to Mary Ann Hawthorne, Director of Nurses.

THE LIFE AND WORKS OF JOHN J. SIPPY

W. P. SHEPARD, M.D., M.A., F.A.P.H.A., Third Vice President, Health and Welfare Division, Metropolitan Life Insurance Company, San Francisco

This is the second and concluding part of "The Life and Works of John J. Sippy." The first part appeared in the October 31st issue of *California's Health*. This paper was presented by Doctor Shepard as the First John J. Sippy Memorial Address before the 1950 meeting of the Western Branch, American Public Health Association, in Portland May 31st. Doctor Sippy served as health officer of the San Joaquin Local Health District for 26 years, from its inception in 1923 until two weeks before his death in March, 1949.

San Joaquin Local Health District, 1923-1949

San Joaquin County, California, was in a bad way and had enough intelligent citizen leaders to know it. In 1921, they had had 645 cases of and 43 deaths from diphtheria, mainly in the town of Lodi, with a population of less than 5,000. In 1922, there were 313 cases, and physicians of that county always carried the necessary instruments for tracheotomy and intubation. They had more malaria than other parts of the State and that was plenty. They had 114 cases of typhoid fever reported in 1922 and many more unreported. It was peculiarly hard to reach because it was largely among itinerant farm laborers in the great fertile delta region at the mouth of the San Joaquin.

With wise leadership from the State Department of Health and the county itself, the California Legislature had passed an enabling act which created a separate health district with its own taxing body, thus removing the county health department from politics and from legislative budgetary pressure. No wonder Sippy was attracted to this challenge and opportunity. When Walter Hogan, long-time City Manager of Stockton, went to the Santa Fe Station to meet the new health officer from Montana, he could not find him. After the passengers had dispersed, he saw a large pile of luggage on the platform and on looking carefully, found John in the midst of his luggage. If Walter Hogan had any misgivings then, they were soon set at rest as the Little Giant swung into action. They soon became great friends and John often remarked that if all health officers had a city manager like Walter Hogan, they would have a model health department too.

No sooner had the new health officer arrived and recruited his able staff when political interests in the county found that they were missing a good bet by losing control of the health department and a suit was filed to test the legality of the enabling act. This resulted in tying up all health department funds. Undaunted, the new health officer and the staunch supporters who had brought him there managed to raise funds by loan from service clubs and other civic organizations which could be drawn upon by staff members to pay their living necessities for the next several months until the suit was settled in their favor.

John Sippy settled down to the biggest job of his life for the next 26 years. What he did in San Joaquin County is well recorded and is familiar to many of us. Suffice it to say, he built it rapidly into a model full-time county health department.

His nursing staff was generalized from the beginning with the exception of bedside nursing. School health work was included from the beginning. His rapid immunization campaigns against diphtheria and smallpox and finally typhoid fever quickly brought the case rate and the death rate down. Once caught up with the backlog of immunizations, he was among the first to abandon the "campaign technique," and to establish a methodical system of immunizing children recorded by the birth certificates during their first year of life. With the help of Dr. Fred Foard, who was loaned by the U. S. Public Health Service, he attacked the typhoid immunization problem by hiring a boat, going from channel to channel in the delta islands and calling the workers from the fields by beating a triangle and proceeding promptly with their immunization. Before long an immunization certificate was required as essential to employment by all delta growers.

In 1922, there were 114 reported cases of typhoid fever. In 1949, there were but seven. In 1923, there were 55 cases of smallpox. There have been none in that county since 1929.[6]

One of Doctor Sippy's first new departures was to establish a dental hygiene program in which all work was carried on by and with the advice and endorsement of the local dental association. He raised private funds for a memorial dental clinic at the emergency hospital and established a fully equipped dentist's office in a truck which was taken from school to school throughout the county.[7]

In 1924, he established a series of diagnostic chest clinics with the help and cooperation of the county medical society. In 1927, he organized the San Joaquin Society for Crippled Children, entirely supported by private funds and caring for 1,300 children up to 1949.

In 1928, he introduced audiometer tests in the schools for detecting cases of early deafness. As early as 1930, he organized clinics for acute rheumatic fever and cardiac cases.

In 1932, Lodi, the little city which had been so severely stricken with diphtheria in 1922, was awarded the first prize of the Chamber of Commerce of the United States in its intercity health contest.

In 1934, a psychiatric social worker was employed and a mental hygiene program has been under way since.

The results of public health work are often maddeningly intangible. It is impossible to express them adequately in any way. It is a proved fact, however, that death rates from preventable causes have been markedly reduced during the period of Sippy's health leadership. John Sippy would be the first to say that he was not solely responsible for these startling results. It was the citizens who did it, the doctors, his staff, not he! In his own words, "It is conceded that public health service does cost money—so do fire and police departments. While the latter two serve to some extent as life savers, it must be admitted they are more largely concerned with the protection of property. Property can be replaced—human life cannot. *San Joaquin citizens* believe in health conservation as a matter of economy as well as of humanitarianism."[8]

In 1923, the total crude death rate in San Joaquin County was 17.3 per 1,000. In 1949, it was 11.0, a reduction of 36 percent.

In 1923, the tuberculosis death rate was 195 per 100,000. In 1949, it was 60, a reduction of 69 percent.

In 1923, the infectious diseases, except tuberculosis, carried a death rate of 186 per 100,000. In 1949 that rate was 22, a reduction of 88 percent.

In 1923, the infant mortality was 50 per 100,000. In 1949, it was 32, a reduction of 36 percent.

In 1923, the maternal death rate was 30 per 100,000. In 1949, it was one, a reduction of 97 percent.[6]

If we take only the major preventable causes of death upon which this health officer's greatest efforts were concentrated: tuberculosis, the other contagious diseases, infant deaths and maternal deaths, it is a simple matter to compute the number of deaths which would have occurred from these causes had the reduction not taken place. We find the reduction in tuberculosis in this quarter century resulted in 2,858 fewer deaths; in the other infectious diseases, 1,630 fewer deaths; among infants 313 and among mothers 797 fewer deaths, a total of 5,598. Certainly some, perhaps most of these people owe their lives to John Sippy. Who they are we shall never know. We only know approximately how many.

In the words of Ravenal, "Figures do not measure the terror of epidemics, nor the tears of the mother at her baby's grave, nor the sorrow of the widow whose helpmate has been snatched away in the prime of life. To have prevented these not once but a million times justifies our half century of public health."[9] To have prevented these not once but well over 5,000 times makes John Sippy perhaps the greatest public benefactor ever known to San Joaquin County!

Honors and Recognition

To John Sippy came many honors, none sought, many evaded because of his modesty. Besides those mentioned, he was President of the San Joaquin Medical Society both in 1926 and in 1929, the only member of that society to hold the presidency twice. In 1927, he was elected President of the California League of Municipalities. In 1929, he was President of the Northern California Public Health Association. In 1934, he was a member of the White House Conference on Child Health and Protection, and in that same year, was appointed Associate Clinical Professor of Public Health and Preventive Medicine at Stanford University School of Medicine. Perhaps the greatest honor which his admiring public health colleagues could confer upon him came in 1945 when he was elected President of the American Public Health Association. He held that office for two years, 1945 and 1946, and was the only individual except our founder, Stephen Smith, to hold the office of president for more than one year.

His contributions to the medical and public health literature were numerous and varied. They are available in the various indexes in the libraries. Suffice it to say that they covered sanitary surveys, infant and maternal death rates, relationships between the health officer and the public health nurse, the relation of city planning to public health, the advantages of dentistry as part of the public health program, communicable disease control in relation to public health nursing, tuberculosis control, evolution of the county health unit, opposition to including medical relief activities in a public health department, the venereal disease problem in transients, the health department's relation to child welfare, the medical profession and the child health program.

Accoucheur for the Western Branch

Before concluding, it is important to record Doctor Sippy's early interest in the organization of this Western Branch of the American Public Health Association. It was in 1924 that Mr. Harry B. Hommon, then District Engineer for the United States Public Health Service, Mr. Charles Gilman Hyde, Professor of Sanitary Engineering at the University of California, and I, encouraged by Mr. Homer Calver, then Executive Secretary of the American Public Health Association, persuaded Dr. William C. Hassler, then long-time City Health Director of San Francisco, to head a temporary organizing committee to explore the desirability of es-

tablishing a western office of the American Public Health Association. One of the first western members of the American Public Health Association chosen by Hassler to serve on this committee was Doctor Sippy. Doctor Hassler cleared the matter with Doctor Chapin, then President of the American Public Health Association in 1927. In May of 1928, Dr. Herman Bundesen, Health Commissioner of Chicago, and then President of the American Public Health Association, appointed the following Western Branch Organizing Committee: Dr. William C. Hassler, Chairman; Dr. E. T. Hanley of Seattle, Vice Chairman; Dr. John J. Sippy, Secretary; Dr. J. L. Pomeroy of Los Angeles; Dr. George Parrish of Los Angeles; Dr. James J. Waring of Denver; Dr. Robert A. Peers of Colfax, California; Mr. Harry B. Hommon of San Francisco; Dr. H. E. Young of Victoria, British Columbia; Dr. F. D. Stricker of Portland; Dr. W. F. Cogswell of Montana; and Dr. W. P. Shepard of San Francisco.

This committee, together with more than a score of other members of the American Public Health Association, met in Portland, Oregon, on June 18, 1928, when Doctor Sippy acted as Constitutional Secretary and Dr. W. Frank Walker, then Field Secretary of the American Public Health Association, took the minutes. When election of permanent officers took place, Doctor Sippy eluded us as secretary, as he was so skillful in doing, and I was elected.

The newly elected officers had their troubles, both in the West and with the eastern office for some little time and it was not until 1930 that the principle of forming a western branch was approved by the Governing Council of the American Public Health Association and we were so notified in a wire from Dr. A. J. Chesley, then president of the association, and Dr. W. S. Rankin, Chairman of the Executive Board. Meanwhile, at the same time the western branch was being formed, there were also organized a Northern California Public Health Association and a Southern California Public Health Association. Although he escaped us as secretary, Sippy took great interest in the western branch from its very beginning. He rarely missed a meeting; he frequently served on important committees; and his wise counsel was always ready and helpful. He was elected president of the western branch in 1941.[10]

Conclusion

It is fitting that we pause long enough in the rapid onward movement of public health to reflect on John Sippy's special skills and most valuable characteristics. Recognition of these will make us even better public health workers.

1. Above all things John Sippy believed in local autonomy and developing local leadership and support from local funds. He often spurned federal funds. To this extent he was almost an isolationist and certainly was unique.

2. He liked his job. He stuck to it in one place for 26 years. He was not attracted by offers elsewhere or by invitations to serve on committees and boards located afar. His national recognition truly came from doing his local job so well.

3. He was a bitter opponent of combining medical relief and hospital administration with the public health department. He believed that the health officer had enough to do without being burdened with the medical relief problem and the budgetary responsibilities attendant thereon.

4. John Sippy always insisted on a balanced program, sometimes to the distress of specialists and enthusiasts, but he got special programs started in due time and did them well.

5. He had the greatest respect for the taxpayer. His tax dollars were spent more carefully than his personal funds. During his 26 years the tax imposed by the local health board remained almost the same, .09 cents in 1923, .095 cents in 1949. He believed his own salary should not exceed a certain percentage of the total budget, and on more than one occasion declined an increase voted by his board.

6. He knew the public health law forward and backward. The district attorney often said the doctor knew the law better than he did. Sippy's advice to young health officers was that their very first responsibility was to study carefully the State Sanitary Code and local health ordinances. His was a deep appreciation of the great authority granted the health officer, in some respects exceeding that of the sheriff. But he rarely used that authority and never abused it.

7. John J. Sippy was modest, retiring and unassuming. He sought no honors; they sought him. Visitors from all over the world knocked at his door, were greeted warmly, kept until satisfied and left with admiration and inspiration. They left as though they had felt the benediction of a gentle man, so able and devoted to his job that they were a little embarrassed at not doing better jobs themselves. The very walls of his personally designed health center exuded his personality. In fact, he was sometimes at a disadvantage when out of his own environment.

8. His methods were democratic and homely. They consisted of first, showing the problem to people properly concerned, not writing or orating; second, giving them an opportunity to do something about it, being patient while they might first delay and fumble.

9. Another important characteristic was knowing people, especially leaders. He had an art of quietly insinuating his friendliness, and of acquiring a full

knowledge of who is who and why. He developed better than most, the art of using natural leaders.

10. He followed the basic principles of health education though he rarely called it by that name; that is, demonstrating, persuading, letting the people do what needed to be done, and giving them all the credit. These are basic principles of public health administration, too often overlooked today. They are the antithesis of the older and poorer methods which we have often seen abused; that is, enforcement of the law without education, authoritarianism, trying a case in the newspapers, organizing one group to combat another.

Thus, in the City of Portland where the Western Branch, American Public Health Association, was born 22 years and 19 days ago, we pay homage to a colleague who was a great health officer, a wise counselor, an outstanding example of diligence and skill, a respected colleague and a beloved friend. His life and works improved the health and lengthened the life of countless people during two generations so that they, in turn, might have healthier children, grandchildren, and great grandchildren ad infinitum. What better proof have we of life after death? We are better men and women for having known John Sippy. We are thankful to have known him so long.

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8. Sippy, John J., "Five Years Progress in Health Administration in San Joaquin County, California," San Joaquin Local Health District, 1929.
9. Ravenal, M. P., "A Half Century of Public Health," APHA, N. Y., 1921, p. 16.
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Correction

In the October 15th issue of *California's Health*, page 55, Elmer Bingham, M.D., was listed as health officer of Santa Cruz County. Doctor Bingham is health officer of the San Joaquin Local Health District, Stockton.

State Dental Position

The California State Personnel Board announces an examination December 16th for dentist, with final filing date November 25th. Salary range is $436 to $530. Employment is with the State Department of Public Health, with headquarters in San Francisco. The position requires traveling in Northern and Central California, including Mono, Alpine and Trinity Counties. Applicants must possess a license to practice as a dentist in their home state and must be eligible for such a license in California.

California Mosquito Control Areas to Receive Subvention Funds

Twenty-four mosquito abatement agencies in California have received allotments totaling $400,000 from state subvention funds for the fiscal year, the Bureau of Vector Control, State Department of Public Health, announces. The allocations are determined by the Bureau of Vector Control, acting on advice of the Vector Control Advisory Committee to the State Department of Public Health, and working with local abatement agencies in considering needs, area of control, and nature of program.

Since the state subvention program began in 1946, organized mosquito control areas in California have expanded from some 7,000 square miles to 20,800 square miles. This movement is expected to continue as irrigation practice, industry and population increase throughout the State.

State subvention funds are allocated on a matching basis, and in no case may exceed 50 percent of local financing. Actually, local agencies contribute more than $1,700,000 annually toward the program.

Agencies receiving the allocations are as follows:

Agency	County	Area (sq. mi.)	Local contribution	Subvention
Butte County Mosquito Abatement District	Butte	792½	$67,390 50	$36,000
Consolidated M.A.D.	Fresno	1,038	114,591 70	28,880
Corcoran M.A.D.	Kings and Tulare	90	6,985 00	5,000
Delano M.A.D.	Kern and Tulare	350	25,200 00	9,300
Delta M.A.D.	Tulare	703	70,300 00	22,500
Durham M.A.D.	Butte	64	5,000 00	4,000
East Side M.A.D.	Stanislaus	288	70,395 00	12,200
Fresno M.A.D.	Fresno	302	77,260 00	9,600
Kern M.A.D.	Kern	886	141,372 00	23,000
Lake County M.A.D.	Lake	1,332	4,290 00	4,000
Los Angeles City Health Dept.	Los Angeles	428	42,474 00	10,000
Los Molinos M.A.D.	Tehama	60	5,460 00	5,000
Madera M.A.D.	Madera	550	48,001 19	21,000
Merced M.A.D.	Merced	1,995	89,231 00	40,000
Monterey Co. Health Dept.	Monterey	100	8,986 00	4,000
Northern San Joaquin Co. M.A.D.	San Joaquin	191	29,195 00	8,500
Orange Co. M.A.D.	Orange	537	82,290 00	5,120
Redding M.A.D.	Shasta	19½	14,560 00	4,000
Sacramento Co.-Yolo Co. M.A.D.	Sacramento-Yolo	2,013	117,550 00	32,000
San Diego Co. Health Dept.	San Diego	4,258	16,549 00	8,000
Solano Co. M.A.D.	Solano	911	30,451 00	9,600
Sutter-Yuba M.A.D.	Sutter and Yuba	712½	80,727 00	36,000
Tulare M.A.D.	Tulare	651	30,753 00	22,300
Turlock M.A.D.	Stanislaus	966	77,867 00	40,000
Totals		19,237½	$1,256,878 39	$400,000

Solano Nursing Position

Dr. L. S. McLean, Vallejo and Solano County Health Officer, announces that there are two openings for qualified staff public health nurses. The starting salary for both positions is $3,276 per year, or $273 per month, with provision for adequate travel allowance. Applicants are directed to apply to Miss Margaret Bernard, Director of Nursing, at 228 Broadway, Vallejo.

Statistical Supplement

Compiled as a companion document to the 1948-1949 *California Public Health Report*, the *Statistical Supplement* is now available from the State Department of Public Health. The supplement, designed as a reference volume to be used by those interested in public health problems in California, presents 1948 data in tabular, graphic and summary form. These data reflect population changes and many of the public health problems of the State characteristic of the year 1948.

Initial distribution of the Supplement has been made. Additional single copies may be obtained from the Bureau of Health Education, State Department of Public Health, 760 Market Street, San Francisco 2.

Tropical Health Course Planned for Nurses

A course in Parasitology and Tropical Hygiene will be offered early next year for nurses by the School of Tropical and Preventive Medicine of Loma Linda, California.

Though designed primarily for graduate nurses who are going to the tropics as mission board appointees, the course is considered valuable to any nurse interested in tropical public health. The six-week study represents a full time program and includes instruction in parasitology, laboratory methods, tropical hygiene and sanitation, nutrition, and tropical medicine and nursing. It is believed that this is the first time such a course has been offered to graduate nurses in the United States.

The course will run from February 19 to March 30, 1951, and carries six semester hours credit. Application forms are available from the Director, School of Tropical and Preventive Medicine, College of Medical Evangelists, Loma Linda.

N. I. H. Director Retires

Dr. Rolla E. Dyer has retired as director of the National Institutes of Health. He is succeeded by Dr. William S. Sebrell, who since 1948 has been head of the Experimental Biology and Medicine Institute. This institute, one of the components of N. I. H., is scheduled to be absorbed into the new Institute of Rheumatism, Arthritis and Metabolic Diseases.

California Morbidity Report September, 1950

Civilian Cases

Reportable diseases	Week ending 9/9	9/16	9/23	9/30	Total cases Sept.	5-yr. median 1945-1949 Sept.	Total cases Jan.-Sept. inc.
Amebiasis	7	12	1	11	31	14	
Anthrax							
Botulism							
Brucellosis (undulant fever)	2	2	1	4	9	22	
Chancroid	4	9	3	10	26	43	
Chickenpox	61	70	78	118	327	270	
Cholera							
Coccidioidomycosis, disseminated		1		1	2	5	
Conjunctivitis, acute infections of newborn				1	1	1	
Dengue							
Diarrhea of the newborn						16	
Diphtheria	2	4	4	1	11	43	
Encephalitis, infectious	21	6	9	13	49	21	
Epilepsy	18	31	34	27	110	132	
Food poisoning	4		9		13	19	
German measles	30	20	27	39	116	117	
Gonococcus infection	320	342	463	340	1,465	2,495	
Granuloma inguinale	1				1		
Hepatitis, infectious		10	6	6	22	13	
Influenza, epidemic	9			7	16	16	
Leprosy						1	
Leptospirosis (Weil's disease)							
Lymphogranuloma venereum	7	7	6	2	22	17	
Malaria	2				2	12	
Measles	57	82	56	69	264	213	
Meningitis, meningococcal	3	2	6	1	12	20	
Mumps	103	135	126	144	508	697	
Pertussis	102	87	89	84	362	489	
Plague							
Pneumonia, infectious	39	18	23	46	126	102	
Poliomyelitis, acute anterior	73	105	89	70	337	512	
Psittacosis							
Rabies, animal	1	2	2		5	13	
Rabies, human							
Relapsing fever		1			1	1	
Rheumatic fever, acute	3	7	5	7	22	54	
Rocky Mountain spotted fever							
Salmonella infections*	7	15	10	5	37	13	
Shigella infections (bacillary dysentery)	5	14	14	12	45	21	
Smallpox							
Streptococcal infections:							
Scarlet fever	27	21	33	43	124	153	
Streptococcal sore throat (and "septic sore throat")	3	5	3	3	14	18	
Syphilis**	206	157	197	176	736	1,515	
Tetanus		6	1	2	9	8	
Trachoma			1		1	2	
Trichinosis							
Tuberculosis:							
Respiratory	137	173	189	128	627	635	
Other forms	3	9	6	8	26	43	
Tularemia						1	
Typhoid fever	2	3	1	2	8	17	
Typhus fever						3	
Yellow fever							
					5,488		

* All types of salmonella infections now reportable. Prior to January 1, 1950, only A, B and C types were reportable; hence a five-year median not entirely comparable.

** Corrected cumulative total cases January-August, inclusive. Syphilis—6,261 instead of 1,411.

It would be possible to add 10 years to the average life span of people living in the United States if we made full use of the scientific knowledge now available.—*Thomas Parran, M.D., formerly Surgeon General, USPHS*

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